

Psychiatric rehabilitation today: an overview

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All patients suffering from severe and persistent mental illness require rehabilitation. The goal of psychiatric rehabilitation is to help disabled individuals to develop the emotional, social and intellectual skills needed to live, learn and work in the community with the least amount of professional support. The overall philosophy of psychiatric rehabilitation comprises two intervention strategies. The first strategy is individual-centered and aims at developing the patient's skills in interacting with a stressful environment. The second strategy is ecological and directed towards developing environmental resources to reduce potential stressors. Most disabled persons need a combination of both approaches. The refinement of psychiatric rehabilitation has achieved a point where it should be made readily available for every disabled person.

Key words: Psychiatric rehabilitation, severely mentally ill, sheltered housing, supported employment, case management, assertive community training

The goal of psychiatric rehabilitation is to help individuals with persistent and serious mental illness to develop the emotional, social and intellectual skills needed to live, learn and work in the community with the least amount of professional support (1). Although psychiatric rehabilitation does not deny the existence or the impact of mental illness, rehabilitation practice has changed the perception of this illness. Enabling persons with persistent and serious mental illness to live a normal life in the community causes a shift away from a focus on an illness model towards a model of functional disability (2). Therefore, other outcome measures apart from clinical conditions become relevant. Especially social role functioning – including social relationships, work and leisure as well as quality of life and family burden – is of major interest for the mentally disabled individuals living in the community.

THE INTERNATIONAL CLASSIFICATION OF FUNCTIONING, DISABILITY AND HEALTH

Long-term consequences of major mental disorders might be described using different dimensions. A useful tool was provided by the International Classification of Impairment, Disability and Handicaps (ICIDH), first published by the World Health Organization in 1980 (3). The ICIDH has been recently revised. The revised International Classification of Functioning, Disability and

Health (ICF) (4) includes a change from negative descriptions of impairments, disabilities and handicaps to neutral descriptions of body structure and function, activities and participation. A further change has been the inclusion of a section on environmental factors as part of the classification. This is in recognition of the importance of the role of environmental factors in either facilitating functioning or creating barriers for people with disabilities. Environmental factors interact with a given health condition to create a disability or restore functioning, depending on whether the environmental factor is a facilitator or a barrier.

The ICF is a useful tool to comprehend chronically mentally ill in all their dimensions, including impairments at the structural or functional level of the body, at the person level with respect to activity limitations, and at the societal level with respect to restrictions of participation. Each level encompasses a theoretical foundation on which a rehabilitative intervention can be formulated. Interventions can be classified as rehabilitative in the case that they are mainly directed towards a functional improvement of the affected individual. As such, the nature of an intervention is defined by the goal which is addressed by the intervention.

TARGET POPULATION

Although the majority of the chronically

mentally ill have the diagnosis of schizophrenic disorders, other patient groups with psychotic and non-psychotic disorders are targeted by psychiatric rehabilitation. Today all patients suffering from severe mental illness (SMI) require rehabilitation. The core group is drawn from patients with persistent psychopathology, marked instability characterized by frequent relapse, and social maladaptation (5).

There are other definitions currently used to characterize the chronically mentally ill (6). They all share some common elements, i.e. a diagnosis of mental illness, prolonged duration and role incapacity.

Up to 50% of persons with SMI carry a concomitant diagnosis of substance abuse (7). The so-called young adult chronic patients constitute an additional category that is diagnostically more complicated (8). These patients present complex patterns of symptomatology difficult to categorize within our diagnostic and classification systems. Many of them also have a history of attempted suicide. All in all they represent an utmost difficult-to-treat patient population.

CONCEPTUAL FRAMEWORK

The overall philosophy of psychiatric rehabilitation in mental disorders comprises two intervention strategies. The first strategy is individual-centred and aims at developing the patient's skills in

interacting with a stressful environment. The second strategy is ecological and directed towards developing environmental resources to reduce potential stressors. Most disabled persons need a combination of both approaches.

The starting point for an adequate understanding of rehabilitation is that it is concerned with the individual person in the context of his or her specific environment. Psychiatric rehabilitation is regularly carried out under real life conditions. Thus, rehabilitation practitioners have to take into consideration the realistic life circumstances that the affected person is likely to encounter in his or her day-to-day living (9).

A necessary second step is helping disabled persons to identify their personal goals. This is not a process where those persons simply list their needs. Motivational interviews provide a more sophisticated approach to identify the individuals' personal costs and benefits associated with the needs listed (10). This makes it also necessary to assess the individuals' readiness for change (11,12).

Subsequently the rehabilitative planning process focuses on the patient's strengths (9). Irrespective of the degree of psychopathology of a given patient, the practitioner must work with the "well part of the ego" as "there is always an intact portion of the ego to which treatment and rehabilitation efforts can be directed" (13). This leads to a closely related concept: the aim of restoring hope to people who suffered major setbacks in self-esteem because of their illness. As Bachrach (9) states, "it is the kind of hope that comes with learning to accept the fact of one's illness and one's limitations and proceeding from there".

Psychiatric rehabilitation cannot be imposed. Quite the contrary, psychiatric rehabilitation concentrates on the individual's rights as a respected partner and endorses his or her involvement and self-determination concerning all aspects of the treatment and rehabilitation process. These rehabilitation values are also incorporated in the concept of recovery (14). Within the concept of recovery, the therapeutic alliance plays a crucial role in engaging the patient in

his or her own care planning (15). It is essential that the patient can rely on his or her therapist's understanding and trust (16), as most of the chronically mentally ill and disabled persons lose close, intimate and stable relationships in the course of the disease (17). Recent research has suggested that social support is associated with recovery from chronic diseases, greater life satisfaction and enhanced ability to cope with life stressors (18). Corrigan et al (19) have found that the most important factor facilitating recovery is the support of peers. Therefore, psychiatric rehabilitation is also an exercise in network building (20).

Finally, people with mental disorders and their caregivers prefer to see themselves as consumers of mental health services with an active interest in learning about mental disorders and in selecting the respective treatment approaches. Consumerism allows the taking of the affected persons' perspective and seriously considering courses of action relevant for them (21). In this context, physicians should also acknowledge that disagreement about the illness between themselves and the patient is not always the result of the illness process (22).

CURRENT APPROACHES

As a general rule, people with psychiatric disabilities tend to have the same life aspirations as people without disabilities in their society or culture (23). They want to be respected as autonomous individuals and lead a life as normal as possible. As such they mostly desire: a) their own housing, b) an adequate education and a meaningful work career, c) satisfying social and intimate relationships, and d) participation in community life with full rights.

Housing

The objective of psychiatric reforms since the mid 1950s has been to resettle chronically mentally ill persons from large custodial institutions to communi-

ty settings. Providing sheltered housing in the community for the long-term patients of the old asylums was one of the first steps in the process of deinstitutionalization. Most long-stay patients can successfully leave psychiatric hospitals and live in community settings (24).

Ideally, a residential continuum (RC) with different housing options should be provided. RC ranges from round-the-clock staffed sheltered homes to more independent and less staffed sheltered apartments which eventually allow individuals moving to independent housing in the community (25). Critics of RC contended that: a) up to date RC is rarely available in communities, b) RC does not meet the varying and fluctuating needs of persons with serious mental illnesses, and c) RC does not account for individuals' preferences and choices. Supported housing, i.e. independent housing coupled with the provision of support services (26), emerged in the 1980s as an alternative to RC. Supported housing offers flexible and individualized services depending on the individual's demands. In the meantime, rehabilitation research could demonstrate that supported housing is a realistic goal for the majority of people with psychiatric disabilities (27). Once in supported housing, the majority stay in housing and are less likely to become hospitalized. Other outcomes do not yield consistent results (27).

Work

The beneficial effects of work for mental health have been known for centuries (28). Therefore, vocational rehabilitation has been a core element of psychiatric rehabilitation since its beginning. Vocational rehabilitation is based on the assumption that work does not only improve activity, social contacts etc., but may also promote gains in related areas such as self-esteem and quality of life, as work and employment are a step away from dependency and a step to integration into society. Enhanced self-esteem in turn improves adherence to rehabilitation of individuals with impaired insight (29).

Vocational rehabilitation originated in psychiatric institutions, where the lack of activity and stimulation led to apathy and withdrawal of inpatients. Long before the introduction of medication, occupational and work therapy contributed to sustainable improvements in long-stay inpatients. Today occupational and work therapy are not any longer hospital-based, but represent the starting point for a wide variety of rehabilitative techniques teaching vocational skills (5).

Vocational rehabilitation programs in the community provide a series of graded steps to promote job entry or re-entry. For less disabled persons, brief and focused techniques are used to teach how they can find a job, fill out applications and conduct employment interviews (30). In transitional employment, a temporary work environment is provided to teach vocational skills, which should enable the affected person to move on to competitive employment. But all too often the gap between transitional and competitive employment is so wide that the mentally disabled individuals remain in a temporary work environment. Sheltered workshops providing pre-vocational training also quite often prove a dead end for the disabled persons.

One consequence of the difficulties in integrating mentally disabled individuals into the common labour market has been the steady growth of cooperatives, which operate commercially with disabled and non-disabled staff working together on equal terms and sharing management. The mental health professionals work in the background, providing support and expertise (2).

Today, the most promising vocational rehabilitation model is supported employment (SE). The work of Robert Drake and Deborah Becker decisively influenced the conceptualization of SE. In their "individual placement model", disabled persons are placed in competitive employment according to their choices as soon as possible and receive all support needed to maintain their position (31,32). The support provided is continued indefinitely. Participation in SE programs is followed by an in-

crease in the ability to find and keep employment (33,34). Links were also found between job tenure and non-vocational outcomes, such as improved self-esteem, social integration, relationships and control of substance abuse (32,35,36). It was also demonstrated that those who had found long-term employment through SE had improved cognition and quality of life, and better symptom control (32,36).

Although findings regarding SE are encouraging, some critical issues remain to be answered. Many individuals in SE obtain unskilled part-time jobs. Since most studies only evaluated short (12-18 months) follow-up periods, the long-term impact remains unclear. Currently we do not know which individuals benefit from SE and which do not (37). After all, we have to realize that the integration into the labour market does by no means only depend on the ability of the persons affected to fulfil a work role and on the provision of sophisticated vocational training and support techniques, but also on the willingness of society to integrate its most disabled members.

Building relationships

In recent years, social skills training in psychiatric rehabilitation has become very popular and has been widely promulgated. The most prominent proponent of skills training is Robert Liberman, who has designed systematic and structured skills training since the mid 1970s (38). Liberman and his colleagues packaged the skills training in the form of modules with different topics. The modules focus on medication management, symptom management, substance abuse management, basic conversational skills, interpersonal problem solving, friendship and intimacy, recreation and leisure, workplace fundamentals, community (re-) entry and family involvement. Each module is composed of skills areas. The skills areas are taught in exercises with demonstration videos, role-play and problem solving exercises and in vivo and homework assignments (39).

The results of several controlled studies suggest that disabled individuals can be taught a wide range of social skills. Social and community functioning improve when the trained skills are relevant for the patient's daily life and the environment perceives and reinforces the changed behaviour. Unlike medication effects, benefits from skills training occur slowly. Furthermore, long-term training has to be provided for positive effects (31,40-42). Overall, social skills training has been shown to be effective in the acquisition and maintenance of skills and their transfer to community life (39,43,44).

Keeping relationships

As a consequence of deinstitutionalization, the burden of care has increasingly fallen on the relatives of the mentally ill. Informal caregiving significantly contributes to health care and rehabilitation (45). Fifty to ninety per cent of disabled persons live with their relatives following acute psychiatric treatment (46). This is a task many families do not choose voluntarily. Caregiving imposes a significant burden on families. Those providing informal care face considerable adverse health effects, including higher levels of stress and depression, and lower levels of subjective well being, physical health and self-efficacy (47). Additionally, not all families are equally capable of giving full support for their disabled member and willing to replace insufficient health care systems. Caregivers regularly experience higher levels of burden when they have poor coping resources and reduced social support (48). But families also represent support systems, which provide natural settings for context-dependent learning important for recovery of functioning (49). Therefore, there has been a growing interest in helping affected families since the beginning of care reforms (50).

One area of interest deals with the expectations of relatives concerning the provision of care. Relatives quite often feel ignored, not taken seriously and also feel insufficiently informed by health professionals. They also may feel that their

contribution to care is not appreciated or that they will be blamed for any patient problems. It is no surprise that there is a lot of frustration and resentment among relatives considering the physical, financial and emotional family burden.

Family intervention programs have produced promising results. Family interventions are effective in lowering relapse rate and also in improving outcome, e.g. psychosocial functioning (51). Possibly, family interventions can reduce family burden. Furthermore, the treatment gains are fairly stable (52). But we also have to appreciate that it is not clear what the effective components of the different models are (53). Additionally, family interventions differ in frequency and length of treatment. There are also no criteria for the minimum amount of treatment necessary.

Finally, we have to be aware that most family interventions were developed in the context of Western societies during deinstitutionalization. Family caregiving might be quite different in a different cultural context. This refers to other cultures in total as well as to minority groups in Western societies (45,48,54).

Participation in community life with full rights

As practitioners, we are often confronted with the deleterious effects of stigma and discrimination in the lives of people with serious mental illnesses. Numerous studies have examined stigmatizing attitudes toward people with mental illness (55-62). In recent years, the scientific interest in the perspective of the labeled individual has increased too. There is extensive empirical evidence of the negative consequences of labeling and perceived stigmatization. These include demoralization, low quality of life, unemployment and reduced social networks (63-67). Once assigned the label "mental illness" and having become aware of the related negative stereotypes, the affected individuals expect to be rejected, devaluated or discriminated. This vicious cycle decreases the chance of recovery and normal life.

On the other hand, well-integrated

people with mental illness exhibit better outcomes regarding psychopathology and quality of life (68). The importance of social integration is underlined even more when considering the subjective availability of support: perceived social support predicts outcome in terms of recovery from acute episodes of mental illness (69), community integration (70), and quality of life (35,71,72).

On the basis of comprehensive research in this area during the last decade, several strategies have been developed to fight the stigma and discrimination suffered by those who have mental illnesses (73). Different research centres developed interventions directed to specific target groups relevant for destigmatization, e.g. students (74) or police officers (75). Persons in contact with mentally ill individuals quite often have a more positive attitude. Contact with the mentally ill persons also reduces social distance (62), which is a strong argument in favour of community psychiatry. Other initiatives have targeted stigma by means of more comprehensive programs. The WPA launched one of the internationally best-known programs in 1996 (76). All these initiatives make clear that efforts in re-integrating persons with serious mental illness into community life must be accompanied by measures on the societal level.

DEVELOPING ENVIRONMENTAL RESOURCES

Effective psychiatric rehabilitation requires individualized and specialized treatment, which has to be embedded in a comprehensive and coordinated system of rehabilitative services. But, even when a variety of services are available, they are poorly linked in many cases, and costly duplication may occur.

While developing community support systems, it became obvious that there was a need to coordinate and integrate the services provided, as each involved professional concentrates on different aspects of the same patient. Therefore, as a key coordinating and integrating mechanism, the concept of case management (CM) originated. CM

focuses on all aspects of the physical and social environment. The core elements of CM are the assessment of patient needs, the development of comprehensive service plans for the patients and the arrangement of service delivery (77).

Over the past two decades, a variety of different models of CM have been developed which exceed the original idea that CM mainly intends to link the patient to needed services and to coordinate those services. Today, most clinical case managers also provide direct services in the patient's natural environment. This model is called intensive case management (ICM). ICM is difficult to distinguish from assertive community treatment (ACT).

Stein and Test have developed the basic components of ACT in the 1970s (78). The original program was designed as a community-based alternative to hospital treatment for persons with severe mental illnesses. A comprehensive range of treatment, rehabilitation and support services in the community is provided through a multidisciplinary team. ACT is characterized by an assertive outreach approach, i.e. interventions are mainly provided in the natural environment of the disabled individuals (79).

Research on CM and ACT yielded "mixed" results (80). While the traditional office-based CM approach obviously is less successful, the ACT model was found to be more beneficial when compared with standard care (81). ACT can reduce time in hospital (37), but has moderate or only little effects on improving symptomatology and social functioning (82). The differing features of the respective services might explain the international variation. Six regularly occurring features of successful services were identified: smaller case loads, regularly visiting at home, a high percentage of contacts at home, responsibility for health and social care, multidisciplinary teams and a psychiatrist integrated in the team (83).

THE ROLE OF THE PSYCHIATRIST IN REHABILITATION

The final ingredient of a successful

ACT approach, namely a psychiatrist integrated in a community team, inevitably leads to the question: what is or can be the role of a psychiatrist in rehabilitation? According to Cancro (84), "A properly trained psychiatrist will be able to prescribe psychosocial interventions, such as social skills training, as well as prescribe medication. This does not mean that the individual psychiatrist should be able to do everything from social skills training to vocational rehabilitation to psychoeducation to family support. It does mean, however, that the psychiatrist must know what is needed and where it can be found and must be able to play a role in directing a team of professionals who can serve these patients. Not only will the patients benefit from such an approach but so will our discipline".

Psychiatric rehabilitation is by its very nature multidisciplinary, because of the many different competencies required (85). It goes without saying that monitoring medication is a key task of the psychiatrist. But pharmacotherapy in psychiatric rehabilitation needs some special consideration. Symptom control does not necessarily have the highest priority, as some side effects of pharmacological treatment can weaken a person's ability to perform his or her social roles, and impair vocational rehabilitation. As such, it is no surprise that non-compliance with medication taking is one of the most serious problems in the long-term treatment of persons with serious mental illness (86). Many patients living in the community want to take responsibility for their medication themselves. Training in self-management of medication (87) emphasizes patients' autonomy and increases acceptance of and responsibility for treatment. This also includes the change of medication without consultation within certain limits.

As a matter of course, most psychiatrists do not acquire all relevant skills needed in psychiatric rehabilitation during their training, which is predominantly hospital-based. Young psychiatrists today are primarily trained in diagnostic procedures and prescription of medications directed almost exclusively

to symptom control, and not trained in integrating pharmacological and psychosocial interventions (88). Another side effect of hospital-based training is that young psychiatrists are confronted with the negative developments of difficult-to-treat patients who are frequently re-hospitalized. This is possibly one of the reasons why we found that psychiatrists in institutional settings do not hold fewer stereotypes of mentally ill people than the general population, nor display a greater willingness to closely interact with mentally ill people (89). Therefore, it would be beneficial if the community training of young psychiatrists could take priority over hospital-based training. More training opportunities to experience the patients in the "real world" would allow psychiatrists in institutional settings to develop a more positive perspective and better understanding of persons with severe and persistent mental disorders.

OUTLOOK

Up to date, major developments in psychiatric treatment and care have evolved from psychiatric rehabilitation. This is the most visible part of psychiatric care and as such represents the link to society. The attitude of the public towards psychiatry is mostly influenced by what rehabilitation accomplishes or not. In fact, the US President's Freedom Commission on Mental Health (90) declared that helping affected persons to achieve functional recovery is the main purpose of the mental health care system.

The refinement of psychiatric rehabilitation has achieved a point where it should be made readily available for every disabled person. But we have to be aware that there is a long way between research and practice. Lehman and Steinwachs (91), for example, assessed the patterns of usual care for schizophrenic patients and examined the conformance rate with the treatment recommendations based on existing scientific evidence. The conformance rate was modest, generally below 50%. It seems to be obvious that

current treatment and rehabilitation practice has to be substantially improved in the light of the rehabilitation research available.

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